

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

10901

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

F Gal widow

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct 28 1886

6. (c) If alive, give age years

8. AGE:

Years 59 Months 5 Days 11 hrs. min.

9. Birthplace

Dear Denton, Maryland, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal. Which?

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

19. M. D. or other

Address

19. Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 3 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 26 1945 to Nov 2 1945

and that I last saw her alive on Nov 2 1945

Immediate cause of death

Carcinoma of left breast

DURATION

3 years?

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

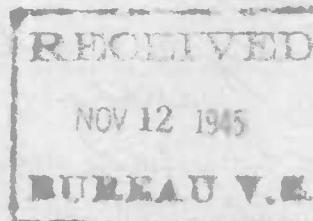
23. SIGNATURE

H. F. Small, M.D.

M. D. or other

Denton, Md. Date signed 11-5-45

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

10902

CERTIFICATE OF DEATH

Reg. Dist. No. 66

1. PLACE OF DEATH:

County.....

City or town.....

Caroline
Ridgely Pines

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

26 years

Hospital, Institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Mary E. Boise

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Fr

C.

Widowed

8. (b) Name of husband or wife

William J. Boise

7. Birth date of deceased (mo., day, yr.)

March 1, 1885

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Queen Anne Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

George Handy

12. Name

George Handy

13. Birthplace

Md.

14. Maiden name

Editha Teat

15. Birthplace

Md.

16. Informant

Louise Gilbert

Address

Woodlyn Pa.

Burial

Date thereof Nov. 21, 1945

(Burial, cremation, or removal. Which?)

Cremated

Cemetery or crematory

Denton

Location

Denton Md.

18. Funeral director

Raymond B. Paulings

Address

Greensboro Md.

19. Nov. 20 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

2nd

County.....

Caroline

City or town.....

Ridgely Pine

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 17 1945 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 1945 to Nov. 17 1945

and that I last saw her alive on Nov. 17 1945

Immediate cause of death

Uremia

Due to

Atherosclerosis
Cardiovascular Disease

Due to

Other conditions

Central Hemorrhage

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

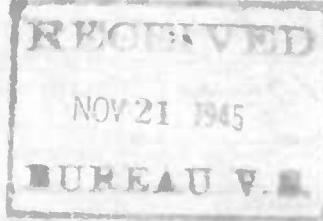
23. SIGNATURE

M. D. or other

Address

Signature

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

CERTIFICATE OF DEATH

10903

61



1. PLACE OF DEATH: Caroline
 County
 City or townGreensboro Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?Life
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

3. (a) FULL NAME charlie Boyd.

4. Sex m 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed.

6. (b) Name of husband or wife Amanda.

7. Birth date of deceased (mo., day, yr.) Jan 5, 1860 6. (c) If alive, give age years

8. AGE: Years 85- Months Days If less than one day hrs. min.

9. Birthplace Caroline Co Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Joshway Boyd

MOTHER FATHER 12. Name Joshway Boyd

13. Birthplace Md

14. Maiden name Vinson

15. Birthplace Md

16. Informant Lewis Boyd.

Address Greensboro Md

17. Burial Date thereof Nov 14 45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greensboro

Location Greensboro Md.

18. Funeral director Raymond B. Rawlings

Address Greensboro Md.

19. (Date rec'd by registrar) Nov 13 1945 J. Mulvey

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State MD County Caroline
 City or town Greensboro Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1945 at 9:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 5 1945 to Nov. 11 1945

and that I last saw him alive on Nov. 10 1945

Immediate cause of death Armenia

Due to Armenia

Armenia

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

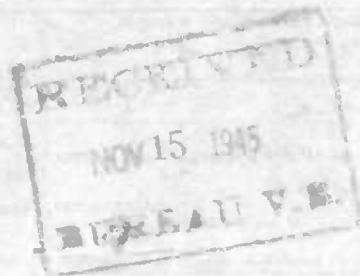
23. SIGNATURE Raymond B. Rawlings M. D. or other Physician

Address Greensboro Md. Date signed Nov 13 1945

ATTACH TO DEPARTMENT STATE CABLEGRAM

ATTACH TO DEPARTMENT STATE CABLEGRAM

RECORDED NOV 15 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 63

1. PLACE OF DEATH:

County CarolineCity or town Preston - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years

Hospital, Institution, or street address where death occurred:

Mt. Pleasant Road

How long in hospital or institution? _____

3. (a) FULL NAME

Annie R. Jones

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

Colored

Married

6.(b) Name of husband or wife

Samuel E. Jones8.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.)

July 7, 1891

8. AGE:

Years
54Months
3Days
24If less than one day
hrs. min.

9. Birthplace

Talbot County, Maryland

(Town, county and state)

10. Usual occupation

Housework

11. Industry or business

Home

FATHER

12. Name

Alfred Green

MOTHER

13. Birthplace

Talbot County, Maryland

14. Maiden name

Alice Cuff

15. Birthplace

Talbot County, Maryland

16. Informant

Samuel E. Jones

Address

Preston, Maryland, R.F.D.

17. Burial

Date thereof November 6, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Prestonown Cemetery

Location

Near Preston, Maryland

18. Funeral director

J. J. Frampton and Son

Address

Federalsburg, Maryland

19. Nov. 4

1945

C. W. Klummer

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarolineCity or town Preston - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Mt. Pleasant Road

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

219-07-5081

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 1, 1945, at 4:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 hours to 12 hours 1945, to Death 1945,and that I last saw h.c.p. alive on October 27, 1945.Immediate cause of death Chronic Myocarditis.TrulyDr. L. H. JohnsonMDmmmmmmDue to Chronic Myocarditis.5 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

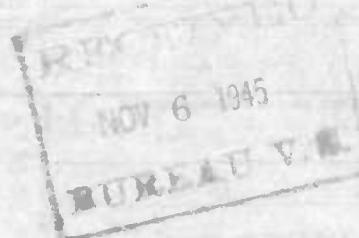
23. SIGNATURE

J. J. Frampton

M. D. or other

Address 11314

STATE TO INVESTIGATING STATE CHARTERED
POLICE GO AHEAD WITHIN



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-4

CERTIFICATE OF DEATH

10905
Reg. Dist. No. 60

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Caroline
 County: Marydel (Rural)
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs.
 Hospital, Institution, or street address where death occurred: _____
 How long in hospital or institution?: _____

3. (a) FULL NAME Emma Jones
 4. Sex F. 5. Color or race Black 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Joseph H. Green
 7. Birth date of deceased (mo., day, yr.) June 1, 1885
 8. AGE: 60 Years 5 Months 25 Days If less than one day _____ hrs. _____ min.
 9. Birthplace Baltimore Md. (Town, county, and state)
 10. Usual occupation House wife
 11. Industry or business Unknown
 MOTHER FATHER
 12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown
 16. Informant Clarence Burris
 Address Marydel Md.
 17. Burial Burial Date thereof 11/28/65
 (Burial, cremation, or removal. Which?) Date (month) (day) (year)
 Cemetery or place Prices
 Location Marydel Rural
 18. Funeral director P.B. Rawlings
 Address Greensboro, Md.
 Nov 27 1945 A.C. Smith
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Caroline
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)
 2.(a) If veteran, name war: _____

3. (b) Social Security Number ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1945 at 10:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1945 to Nov. 25 1945 and that I last saw her alive on Nov. 25 1945.Immediate cause of death Tubercle DURATION _____Due to Cleonic Lepto DURATION _____Due to Cleonic Myocarditis DURATION _____

Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

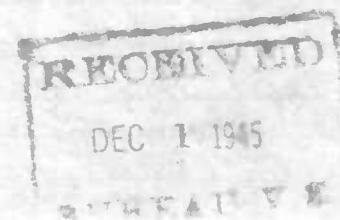
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Clarence B. Smith D. of PriceAddress Prices for bed Date signed 1945

RECEIVED BY THE STATE OF ILLINOIS

RECEIVED - 50 REPLICAS



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

10906

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:

County.....*Caroline*
 City or town.....*Greensboro*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *15 months*
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution? *15 months*

3. (a) FULL NAME

Mary Mc Knett

4. Sex <i>Female</i>	5. Color or race <i>white</i>	6. (a) Single, married, widowed, or divorced <i>widow</i>
-------------------------	----------------------------------	--

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Sept 14, 1869* (c) If alive, give age years

8. AGE: Years <i>76</i>	Months <i>2</i>	Days <i>7</i>	If less than one day hrs. min.
----------------------------	--------------------	------------------	--------------------------------------

9. Birthplace *Talbot Co. Md.* (Town, county, and state)

10. Usual occupation *Retired*

11. Industry or business *Trust officer*

12. Name <i>Joseph Merrick</i>

13. Birthplace <i>Talbot Co. Md.</i>

14. Maiden name <i>Sarah Jane Berry</i>
--

15. Birthplace <i>Talbot Co. Md.</i>

16. Informant *Mrs. Eddie Cryer*

Address *Trappe, Md.*

17. Burial *Burial* Date thereof *Nov. 24, 1945* (month) (day) (year)

Cemetery or crematory *Spring Hill*

Location *Talbot Co. Md.*

18. Funeral director *Maurice E. Newman & Son*

Address *Talbot, Md.*

19. Nov. 24, 1945 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md.* County.....*Talbot*

City or town.....*Talbot* (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 21, 1945* at *7:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 5, 1944, to Nov. 21, 1945
 and that I last saw her alive on *November 20, 1945*

Immediate cause of death

Cerebral Hemorrhage

Due to *Cerebral Hemorrhage*

With hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *Death W. J. Newell Jr.* M. D. or other

Date signed *1945*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The ~~forget~~ age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of
age is shown on
G 99 12-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

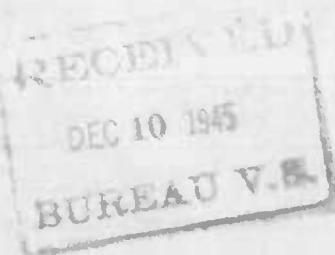
2411 N. Charles St., Baltimore 8304

10907

CERTIFICATE OF DEATH

Reg. Diat. No. 64

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death?..... Hospital, Institution, or street address where death occurred: Bevna Vista Avenue			Street No. Bevna Vista Avenue (If rural, give LOCATION)			
How long in hospital or institution?.....			2.(a) Is veteran, name war..... No			
3. (a) FULL NAME Raymond W. Noble			3. (b) Social Security Number None			
4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married			MEDICAL CERTIFICATION			
6.(b) Name of husband or wife Ala. Noble			20. DATE OF DEATH November 29, 1945, at 11:15 A.M.			
7. Birth date of deceased (mo., day, yr.) July 25, 1887			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24-25, 1945, to Nov 29, 1945 and that I last saw h.l.m. alive on Nov 29, 1945			
8. AGE: Years 58 Months 5 Days 4 6.(c) If alive, give age..... 55 years hrs. min.			19. DURATION 5 days			
9. Birthplace Dorchester County, Md. (Town, county, and state)			Immediate cause of death Cerebral hemorrhage			
10. Usual occupation Postmaster			Due to Hypertension			
11. Industry or business U.S. Post Office			Due to			
FATHER	12. Name John Henry Noble			Other conditions (Include pregnancy within 8 months of death)		
	13. Birthplace Dorchester County, Md.			Major findings of operations Date of op.		
MOTHER	14. Maiden name Lavinia Carkron			Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.		
	15. Birthplace Dorchester County, Md.			22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of.....		
16. Informant Mrs. Ala Noble			Where did injury occur?..... (City or town) (County) (State)			
Address Federalsburg, Md.			Injured at home, farm, industry, public place (where?).....			
17. Burial (Burial, cremation, or removal. Which?) Date thereof December 1, 1945 (month) (day) (year)			Means of injury Injured at work?			
Cemetery or crematory Hill Crest Cemetery			23. SIGNATURE Frank M. Anderson, M.D. or other Address Federalsburg, Md. Date signed 1/30/45			
Location Federalsburg, Md.						
18. Funeral director J. J. Frampton and Son						
Address Federalsburg, Maryland						
19. December 1, 1945 (Date rec'd by registrar)						
J. S. Frampton Registrar						



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 167

CERTIFICATE OF DEATH

16908
62

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Caroline

City or town..... Denton Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Francis B. Potts

4. Sex

F

5. Color or race

R.

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Sept 2.

8. (c) If alive, give age..... years

1911

8. AGE:

Years

Months

Days

If less than one day

34

2

24

. hrs. . min.

9. Birthplace.....

Greensboro Caroline Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

Herbert Potts

12. Name.....

Herbert Potts

13. Birthplace.....

Md

14. Maiden name.....

Blanche Weing

15. Birthplace.....

Md

16. Informant.....

Rachel Bee

Address.....

Greensboro Md.

17. Burial, cremation, or removal (which?)

Burial

Date thereof Nov. 29. 45

(month) (day) (year)

Cemetery or crematory.....

Cofflers

Location.....

Near Greensboro Md

18. Funeral director.....

Raymond B. Rawlings

Address.....

Greensboro Md

19. Rec'd by registrar.....

Tues. 26 Nov. 45

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Pennsylvania County..... Chester

City or town..... Chester

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 833 S. Murray St

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

220-01-0353

MEDICAL CERTIFICATION

Nov. 25

1945 at 8:30 p.m.

20. DATE OF DEATH..... 1945 to 1945

and that I last saw h..... alive on

1945

Immediate cause of death.....

External Hemorrhage

DURATION

Due to.....

Stab wound of Chest

.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Homicide Date of 11/25/45

Where did injury occur? Denton Caroline Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Streets of Denton

Means of injury State wound Injured at work? No

23. SIGNATURE

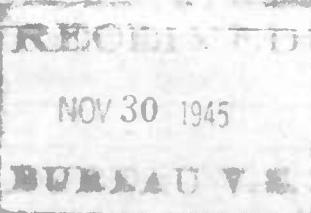
Hanson George coroner M. D. or other

Address..... Denton Md Date signed 11/26/45

ATTACHED TO TATTOOED STATE 607, ITALY

NOV 30 1945

RECORDED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

10909

CERTIFICATE OF DEATH

Reg. Dist. No. 63

1. PLACE OF DEATH:

County CarolineCity or town Choptank

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William E. Stewart

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Grace P. Stewart6. (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.)

July 12, 1884

8. AGE:

Years
61Months
3Days
24

It less than one day

hrs.

min.

9. Birthplace

Moore County, North Carolina

(Town, county, and state)

10. Usual occupation

Mechanic

11. Industry or business

Carpenter

12. Name

Peter Stewart

13. Birthplace

North Carolina

14. Maiden name

Margaret Shields

15. Birthplace

North Carolina

16. Informant

Mrs. Grace P. Stewart

Address

Choptank, Maryland

17. Burial

Date thereof November 9, 1945
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

Linchester Cemetery

Location

Near Preston, Maryland

18. Funeral director

J. J. Frampston and Son

Address

Federalsburg, Maryland

19. Nov. 8 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarolineCity or town Choptank

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

218-14-2586

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 6

1945

at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March

1944

to November 6, 1945and that I last saw him alive on November 6

1945

1945

Immediate cause of death

Embolus

DURATION

24 hoursDue to Chronic Myocarditis

SYMPTOMS

Due to

Other conditions Senile Hypochromic
anemiaDURATION
1 yr. +

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

William C. Harrison MD

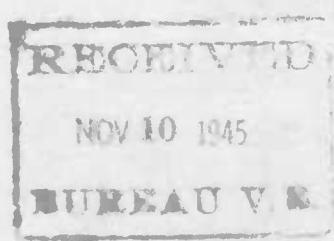
M. D. or other

Address

Hurlock Md.

Date signed

11/7/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

16910

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:

County Caroline

City or town Preston R. F. D. Near Harmony
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Raymond D. Williamson

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mary E. Williamson

6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.)

October 8, 1895

8. AGE:

Years 50

Months 1

Days 21

If less than one day hrs. min.

9. Birthplace

Caroline County Maryland
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name John W. Williamson

13. Birthplace Caroline County, Md.

MOTHER

14. Maiden name Laura F. Williams

15. Birthplace Caroline County, Md.

16. Informant

Mrs. Mary E. Williamson

Address

Preston, Maryland R. F. D.

17. Burial

Date thereof Dec. 9 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Federalsburg Maryland

18. Funeral director J. J. Frampton and Son

Address Federalsburg Maryland

19. December 1 1945
(Date rec'd by registrar)J. S. Frampton
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Preston Md. R. F. D. Near Harmony
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

no

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1945 at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10

1939

to November 29 1945

and that I last saw h. s. alive on November 28 1945

Immediate cause of death

Cerebral hemorrhage

DURATION

5 days

Due to cerebral arteriosclerosis

2 yr

Due to

Other conditions general arteriosclerosis

4 hr

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

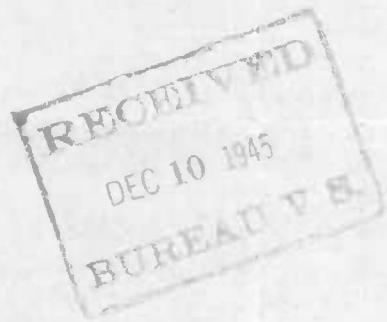
Injured at work?

23. SIGNATURE

J. Paul Throats M.D.

M. D. or other

Address Weston Rd. Date signed 11/30/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

10911

CERTIFICATE OF DEATH

Reg. Dist. No. 66

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Oct. 13² 1945

8. AGE:

Years

Months

Days

If less than one day

1 2 hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or tow.....

(If outside city or tow limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

Nov 15 1945, al 6A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

DURATION

Due to Found dead in bed, having
fallen Paroxysm sudden

Due to in bed

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

